Letters to the Editor...

Children, the Victims of Fragmentation Of Health Services

CHILDREN are important. They are the men and women of tomorrow. Their physical, mental, and emotional well-being is the responsibility of the medical and allied professions. There is a great deal of money, public (federal, state, and local) and private, (a charity fund for every day of the year) expended and yet it is practically impossible to finance adequately simple programs of child care. The delinquency rate, the neurotic and psychotic statistics, indicate that such programming is important and should be supported.

At the end of World War II the Academy of Pediatrics sponsored a nationwide study of health services for children. I participated in the study and for several years thereafter attended national committee meetings concerned with medical education leading to better child health care. For the past 10 to 15 years as Chief of Pediatrics at Children's Hospital I have tried to analyze the nearly insurmountable problems encountered in programming for children in need of special help. This communication is an attempt to record the findings of this study. Three different groups of children will be briefly reviewed: (1) The handicapped child, (2) the deprived child, and (3) the health problems of the normal child.

The Handicapped Child

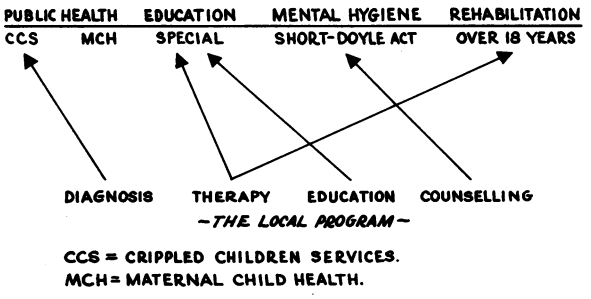
Children with a chronic or longterm handicap such as central nervous system disease, blindness, deafness, cardiac anomalies, metabolic diseases, congenital defects, etc., need planning, as follows: (a) diagnosis, (b) therapy, (c) education, and (d) counseling. The planning and staffing for this type of program is not difficult nor unduly expensive, especially if the preventive aspects of such programming are considered. The financing and the execution of the program is well nigh impossible. Diagram 1 is an attempt to clarify the reasons. Money for diagnosis of some diseases can be obtained through Crippled Children Services. The C.C.S., however, has grown haphazardly and new diseases have been added without overall planning. This leads to some difficulty. The Crippled Children Services should be reviewed and the diseases coming under their jurisdiction reevaluated. This should not be too difficult a procedure and certainly calls for pediatric participation in any such reevaluation.

Diagnosis, however, is the easiest part of the problem. When therapy is contemplated the Crippled Children Services give very little direct assistance except for surgical procedures. The daily therapy, for instance, of the cerebral palsy child is administered only through the school system and the financing comes down through the Department of Education. Crippled Children Services can participate in therapy for the cerebral palsy child only through this system. The clinics for the cerebral palsy child are set up in the School Department. Originally these clinics were conducted by orthopedists and to a large extent they still are so conducted. It a patient has minimal motor involvement but a learning problem such as an expressive aphasia, he is not eligible for such a clinic. If he is too handicapped to be educable, he has no choice for therapy except through the school clinic. As the crippling problems became recognized earlier in the child's life, schooling was pushed back to accommodate the kindergarten children and then the nursery school children. Now that these conditions are often recognized at birth or shortly thereafter, these babies have to go to the school clinic to get any help and usually the type of help that is given in the school clinic is not either what the child or the parents need.

Legislation for day care for the severely handicapped uneducable child is also in the hands of the Department of Education. This group of children need nursing care as they are untrained, they are not educable and usually not trainable, they are subject to convulsions. Physiotherapy and occupational therapy will help them some but mostly they present a problem of day custodial care. It is "baby-sitting" and educators should spend their time at something besides baby-sitting. These day care centers should be under pediatric supervision and associated with hospitals.

The education and training of the handicapped child is also exclusively in the hands of the educators. There are state schools for cerebral palsy, the blind, and the deaf; there are local schools for children with motor handicaps; there are schools and classes for the deaf, the blind, and the retarded. The function of each of these schools is clearly defined

DIAGRAM 1- FRAGMENTATION OF SERVICES



CCS = CRIPPLED CHILDREN SERVICES.
MCH = MATERNAL CHILD HEALTH.

and limited. The admission, retention, or expulsion of a pupil is under the control exclusively of the educators.

A handicapped child rarely escapes with only one handicap. There is no provision made for a cerebral palsy child who is blind and/or deaf. The deaf school will not take him; the blind school will not; and the cerebral palsy school will not accept him. The same applies to a hyperkinetic child with or without retardation. A similar policy is practiced in the state school for these handicaps.

A handicapped child needs repeated evaluation and the parents need counseling. This calls for the services of psychologists and social workers. State money for such services comes through the Mental Hygiene Division, more particularly the Short-Doyle Act. Again, these funds are so delimited and their use so defined that it has been impossible to utilize these monies for help for either the handicapped or retarded in the program.

The rehabilitation services of the state, again a separate department, are limited primarily to adults over 18.

The private charity fund drives raise a tremendous amount of money and our people are willing to give to these funds. Again, each charity clearly defines its function. It will support only its own specific disease and only in its own prescribed manner. The result is that children in need of help either fall between the charities or their heads fall in one classification and their feet in another. The charity table is heaped with good intentions but the children and the programs aimed at helping these children get only the crumbs that fall from this table.

A possible solution to the above fragmentation at the state level would be removal of the children from all of these divisions and the creation of a special department for the handicapped child. This naturally should be in the Department of Health with a pediatrician in charge. Members of the other divisions, namely, Education, Mental Hygiene, and Rehabilitation, should work in close cooperation but be ancillary to the pediatrician in charge of such a division.

At the local level the programming and habilitation for these services should be in hospitals, again, under pediatric supervision. The clinics should be removed from schools where they do not belong and placed in hospital settings.

Those in charge of the charity funds should make a determined effort to look at the children and their needs and support these programs accordingly rather than by the sharp delineation which is now practiced. It would be timely also to determine how much of these funds are "consumed" before they reach the children.

The Deprived Child

The Public Welfare Department has a division known as Aid to Needy Children (A.N.C.). This aid, however, includes the parents, primarily the mother, of the needy child. The medical program, probably in part to economize by utilizing existing facilities but also possibly in order to please the private physician, was set up as follows: (1) Well child care was to be obtained through the existing well baby clinics; (2) hospitalization, when necessary, was delegated to the county hospital; (3) private physicians would be paid for making home calls on the sick. The result of this program is a discontinuity of care that baffles the patient and has completely discouraged the physician. The private physician can treat an A.N.C. child for diabetes but if that child gets a severe infection or goes into diabetic coma he is sent to the county hospital to be treated by a new set of doctors. Pediatricians have told tales of how after a diagnosis of acute appendicitis or pneumonia the child was sent to the county hospital only to be sent home with the statement that he was eligible for private care. These tales are innumerable.

In order to eliminate some of this fragmentation a group of pediatricians, after meeting and discussing the problem, suggested the following, namely, that well child and routine care be in existing hospital clinics, including the well baby clinic in the hospital. This same hospital should then be utilized for any illnesses of the patients registered with them. A group of staff physicians would volunteer to make home calls on patients so registered. This suggestion has been sent to the local county medical society and to the community chest.

The Normal Child

Practically all specialties in medicine see children in some capacity and yet most of the physicians in specialties other than pediatrics have had little or no training in childhood diseases or with children per se beyond that given in undergraduate medicine. There is now a tendency to have straight internships and even in many rotating internships pediatrics is reduced to one month. This lack of training in the characteristics of the young has serious implications. The toxicity of drugs is not sufficiently tested for the young with consequences such as blindness from excess oxygen, gray baby deaths from chloromycetin, etc.

The hazards of radiation have been given a little more attention but this is still largely in the "lip service" stage.

Although there is an increasing number of pediatricians in the subspecialties such as allergy, metabolic diseases, cardiology, hematology, etc., these conditions are still often handled by internists who know a great deal about the disease but very little about the child, his growth, or his ego needs.

The surgical specialties are the greatest offenders. These add to the hazards of medication and emotional trauma those of anesthesia and hypoxia to the growing brain. Frequently also, because of lack of knowledge of the child, water intoxication occurs or excess blood is given. The pediatric surgeon has had a formidable struggle indeed to get recognition.

Since children are our greatest asset, the medical school should not end the study of growth of human beings with the completion of the course in embryology. Growth, development, maturation, aging, and ecology should be a basic course in the medical school continuous through the undergraduate years. Every specialty and subspecialty that deals even remotely with children should be required by their respective boards to have an intensive course in pediatrics before certification.

Although this communication deals with children, the same situation probably exists to a varying degree in all of medicine and the allied services. Is it not opportune that as physicians we take some active steps to remedy it?

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What Constitutes an Adequate Exploration in the Abdomen

NOT INFREQUENTLY exploration of the abdominal-pelvic viscera at laparotomy is an exceedingly casual affair. Two recent cases which have come to my attention, point up the necessity of carrying out the above in an orderly and detailed fashion if the patient is to receive the best we have to offer in the way of treatment when the abdominal cavity is opened. Both cases were those of intestinal bleeding in which duodenal deformities were demonstrated by x-ray. The hemorrhage was massive and the patients were explored. In neither case was the gastrointestinal bleeding from the duodenal ulcer, yet in both, definitive surgical treatment was carried out for a duodenal ulcer. In both instances the patients bled again and subsequent therapy of a surgical nature was required. In one instance a re-resection was carried out without benefit to the patient and in the other instance the patient was found to have a Meckel's diverticulum from which he was bleeding. In the first instance the patient finally succumbed to the hemorrhage and at autopsy a large gastric ulcer high in the stomach was detected which had not been demonstrated by x-ray nor had it been diagnosed at the time of exploration. These are merely two incidences which could have been eliminated had adequate exploration been carried out.

The pancreas and the adrenal glands are other structures that are often neglected during examination. Except in emergency conditions, it should be the invariable practice of all surgeons who open the abdomen, to palpate every structure within the abdominal-pelvic cavities and to record the observations in the operative notes. To complete an exploration and describe such at the end of an operation with the note, "The remainder of the abdominal exploration was negative," or to have only some abdominal viscera described in the operative note with no mention of the other organs, is poor practice and one which, unfortunately, is common today. A system for exploration should be developed by every surgeon. One method is to explore the pelvic and abdominal cavity starting at a point usually removed from the site of pathology anticipated or known pathologic condition. In dictating the operative report, every structure is described and recorded including all intraperitoneal as well as extraperitoneal organs which are palpable through abdominal incisions. This is particularly important in relation to the kidney and pancreas for routine exploration enhances one's ability to detect and distinguish diseases of the pancreas and kidney when they are present.

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